Doula Support and Attitudes of Intrapartum Nurses: A Qualitative Study from the Patient's Perspective

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ABSTRACT

Although the roles of the intrapartum nurse and professional doula differ markedly, they serve women best if their roles complement each other. For doulas and nurses to work well together in order to facilitate a positive birth experience for the patient, they would logically need to develop a relationship based on mutual respect. The purpose of this pilot qualitative study was to examine the level of acceptance shown by intrapartum nurses for doula support, as perceived by the parturient woman. Implications for further research are addressed.

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HISTORY OF CHILDBIRTH IN AMERICA

The idea of women helping other women during childbirth is not new. Long before the field of obstetrics was developed, women assisted other women in bringing their children into the world. For many years, American childbirth practices—strongly influenced by practices in England—followed the social childbirth philosophy. Women labored and gave birth at home and were attended by lay female friends, relatives, and traditional midwives. These attendants viewed their role as sustaining the strength of the individual and assuring her of her progress. After birth, a woman remained with her female support system for a period of "lying in," during which she recuperated and became acquainted with her new child (McCool & Simeone, 2002, p.736). These qualities of togetherness, caring, and support encouraged the persistence of the social childbirth philosophy throughout the nineteenth and early twentieth centuries.

By 1930, growing differentiations in social class and an increasing value placed on the medical profession caused a shift from the social childbirth philosophy to a medical-illness model (McCool & Simeone, 2002). The traditional midwives, often black or European immigrants who had been trained either by apprenticeship or at European midwifery schools, were practically abolished (Dawley, 2000). Childbirth became a means of demonstrating new advances in technology and medicine, and women

For more information on the role of a doula, including how to locate a doula in your area, visit the DONA Web site (www.dona.org).

began to birth their babies in hospitals with the aid of primarily male physicians. "While the shift was of enormous benefit to high-risk mothers and babies, it subjected low-risk mothers to a battery of interventions that are often counterproductive to healthy labor and delivery" (Yale, 2002, p. 253).

In the 1920s, routine use of forceps during uncomplicated births was promoted. Anesthesia became widely used during the 1940s. By 1950, most women were not alert or even conscious while giving birth. Subsequently, continuous caudal anesthesia was developed and, soon after, was followed by introduction of continuous lumbar epidural anesthesia in the 1960s. In the early 1970s, electronic fetal monitoring was introduced into the delivery rooms (McCool & Simeone, 2002).

Although these advancements allowed women to remain conscious and freed nurses to care for multiple patients, they reduced the centuries-old practice of ambulation during labor to a relic of the past. Birth attendants were no longer present at bedside throughout labor to offer support. Because friends and family were not allowed to visit, bed confinement further isolated the mother from any potentially supportive individuals.

THE NEED FOR DOULA SUPPORT

Childbirth interventions are currently at an all-time high. The cesarean rate is over 24%, the induction rate is 44%, the rate of epidural use is 63%, the rate of artificially rupturing membranes is 55%, and the episiotomy rate is 52% (Sakala, Declercq, & Corry, 2002). Most women (75%) are confined to the hospital bed for the majority of their labor and birth in the lithotomy position. The *Listening to Mothers* survey in 2002, which surveyed women's feelings, attitudes, and knowledge about childbirth, identified these routine interventions as "concerns" of mothers (Sakala et al., 2002).

Today, in most hospitals, although family members are welcome during labor and birth, "support" of laboring mothers is usually left to the intrapartum nurses. An inexperienced partner or family member of the woman may assist the nurse in support techniques. Due to the high incidence of short staffing, endless amount of charting, and continuous monitoring required by the nurses, little time is left for tending to the mother's emotional, spiritual, and physical needs. This, combined with many mothers' concern over the high rate of interventions, has resulted in some women choosing to give birth with the assistance of a professional support person or doula.

A doula is defined by Doulas of North America (DONA) as a woman who is trained and experienced in childbirth and provides continuous physical, emotional, and informational support to a woman during labor, birth, and the immediate postpartum period. Women choose to labor and give birth with doula support for a wide range of needs, goals, and concerns about their childbirth experience. Many women want to be encouraged and supported as they give birth without pain medications, while other women desire a liaison between themselves and the medical staff. Some women may have no family to support them through labor, while others simply prefer an experienced female to "take the pressure off" their partner.

HISTORY OF DOULAS

The word *doula* originates from the Greek word for "slave" and was coined in 1976 by Dana Raphael to describe an experienced woman who, after birth, assisted the mother with breastfeeding her baby (Klaus, M., Kennell, Berkowitz, & Klaus, P., 1992). Doulas gained popularity during the 1980s when women became distressed at the ever-increasing rate of cesarean sections. Women began to invite a female friend, their childbirth instructor, or an obstetrical nurse with whom they were friends to provide labor support in order to have an advocate to help them avoid routine procedures that could lead to a cesarean (Gilliland, 2002). Although a primary goal of today's doulas remains helping women avoid unnecessary cesareans, their scope of practice is much broader.

ROLE OF A DOULA

The role of a doula is to provide specific labor-support skills, techniques, and strategies, offer guidance and encouragement, build a team relationship with the nursing staff, encourage communication between the patient and medical caregivers, and assist the mother in covering the gaps in her care. According to DONA (n.d.), a doula's role can be summarized in seven objectives:

1. To recognize birth as a key life experience that the mother will remember all of her life;
2. To understand the physiology of birth and the emotional needs of a woman in labor;
3. To assist the woman and her partner in preparing for and carrying out their plan for the birth;
4. To stay by the side of the laboring woman throughout the entire labor;

5. To provide emotional support, physical comfort measures, an objective viewpoint, and assistance to the woman in getting the information she needs to make good decisions;
6. To facilitate communication between the laboring woman, her partner, and clinical care providers; and
7. To perceive the doula's role as one who nurtures and protects the woman's memory of her birth experience.

Doulas use techniques such as imagery, massage, acupressure, and patterned breathing to reduce a woman's pain. They suggest position changes to accelerate labor or aid in fetal positioning. They also provide guidance and encouragement to minimize fear and anxiety, and encourage touch and communication between the laboring woman and her partner.

THE ROLE OF THE INTRAPARTUM NURSE

According to Gilliland (2002), ''The roles of the obstetrical nurse and the professional doula differ markedly, yet they also overlap somewhat and should compliment each other'' (p. 549). The nurse's role involves clinical skills and administrative responsibilities that are not part of the doula's role. She is responsible for assessing both the mother and baby, administering drugs and intravenous fluids, and stabilizing the newborn. In a study examining pregnant mothers' expectations, nulliparous mothers expected their nurse to spend 53% of her time offering physical comfort, emotional support, information, and advocacy (Tumblin & Simkin, 2001). In a contrasting study, researchers found nurses spent only 6–10% of their time engaged in labor-support activities (Gagnon, Waghorn, & Covell, 1997). A subsequent study identified some of the barriers to supportive care cited by nurses as inadequate staffing, the physical environment, negative staff attitude toward supportive care, and lack of management support (Davies & Hodnett, 2002). This gap in care clearly provides a place in which doulas can assist in providing optimal intrapartum care.

Gilliland (2002) notes, ''For doulas and nurses to work together as a team to provide the best possible care for an intrapartum patient, they must develop a relationship based on mutual respect for each other's different roles'' (p. 550). Conflict between the doula and nurse is highly undesirable. According to Gilliland, conflict ''undermines the mother's confidence in the nurse, doula, medical provider, facility, or any combination of these'' (p. 550). The tension that could arise can have harmful emotional and physical effects for the laboring mother and fetus. Anxiety during labor leads to an endogenous release of catecholamines, which lowers uterine contractility and decreases placental blood flow. Therefore, it is imperative that the doula and the nurse work together and accept each other's roles.

REVIEW OF LITERATURE

In 2002, Bowers conducted a massive meta-analysis to review mothers' perceptions of labor support. Her review spanned 17 studies in a wide variety of birth settings with intrapartum support provided by midwives, nurses, or doulas. Supportive actions were characterized according to the four dimensions of professional labor support: physical comfort, emotional support, informational support, and advocacy. Pain was a major concern during labor, and comfort measures used to relieve pain were considered ''supportive.'' Assistance with breathing, relaxation techniques, acupressure, massage, and hydrotherapy were cited as important. Perceptions of emotional support included the caregiver being friendly, open, and gentle, communicating a warm, positive regard for the laboring woman, and conveying a sense of security and well being. Constant presence was also an important aspect of emotional support. Nurses who were perceived as the most caring demonstrated genuine concern for the woman and her partner. Personalized information from the nurse was important during all stages of labor, especially prior to the performance of procedures. Advocacy also played a role in women's perception of labor support. Women wanted to know their options and have their decisions respected. Understanding the actions that birthing women have reported as important to them can direct the practice of those who provide intrapartum care and serve as a guide for future research.

Other studies have also demonstrated the benefits of continuous labor support. In 1991, a group of researchers replicated a randomized trial that had been conducted in the 1980s in Guatemala (Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991). The study focused on 412 nulliparous

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women with whom a doula stayed during the entire labor. The doula provided touch, encouragement, information, and an explanation of hospital procedures. The study showed that continuous support by a doula significantly reduced the rate of cesarean section and forceps delivery, decreased oxytocin augmentation, and shortened the duration of labor.

In a meta-analysis of the effects of labor support on mothers, women who had continuous labor support had lower rates of analgesia and anesthesia use, lower operative birth rates, shorter labors, fewer newborns with 5-minute Apgar scores less than 7, and increased maternal satisfaction with the birthing process (Sauls, 2002). Some data within the analysis also indicated women with doula support had more maternal-infant bonding, felt less anxious about motherhood, and had a lower incidence of postpartum depression. Sauls's study spanned more than 30 published reports, reviews, commentaries, and randomized clinical trials in five countries, including the United States, Guatemala, South Africa, Canada, and Mexico. Although most of the reviewed studies had limitations, all found evidence of the beneficial effects of labor support. The most powerful of these effects occurred when birth companions other than nurses provided support.

A study by Hodnett (2002) examined pain and women's satisfaction with the experience of childbirth. Surprisingly, the researcher found that the amount of pain a woman experienced during childbirth factored little into her perception of her overall birth experience. However, in every instance, the quality of the relationship with and support from caregivers was a strong predictor of childbirth satisfaction.

Several studies have also suggested that a support person, other than the intrapartum nurse, may be the best provider of supportive care. Rosen (2004) performed a meta-analysis of eight randomized trials in which support provided by different types of caregivers was analyzed. These trials investigated untrained lay women, trained lay women, female relatives, nurses, lay midwives, and student lay midwives as support persons. The researcher found that continuous support by untrained lay women starting in early labor and continuing into the postpartum period demonstrates the most consistent, beneficial effect on childbirth outcomes.

In the *Listening to Mothers* survey, researchers polled 1,583 women who had given birth in the previous 24 months (Sakala et al., 2002). Although doulas and midwives were the least used sources of supportive care (5% and 11%, respectively), they were the best-rated sources of supportive care in labor.

A unique, yet significant role for doulas was examined by Pascali-Bonaro in 2003. Her study examined the impact of stress and grief on pregnant widows of the September 11, 2001, attacks on the World Trade Center in New York City. Pascali-Bonaro's collaborative, interspecialty volunteer program extended for nine months after the attacks, providing free support and counseling by doulas and childbirth educators. Her study demonstrates how doulas can help anxious mothers through childbirth by creating safe, comforting environments, encouraging women to design a birth plan that includes ways to make them feel secure during labor and birth *before* any catastrophic event may occur, and facilitating positive communication between the provider and client. Such data can likely extend to the general childbearing population who, inevitably, also experience at least some degree of tension and anxiety.

Although dozens of studies herald the benefits of continuous labor support and several more studies indicate that a doula may be the best provider of that continuous support, the relationship between doulas and intrapartum nurses has yet to be examined. However, in 1985, Hazle did examine the relationship between nurse-midwives and intrapartum nurses. Her study included 100 nurse-midwives and 100 obstetric nurses. Each group received mailed questionnaires containing five sections: profile, content of care, attitudes and values, role definition, and critical incident report. An analysis of the data compared activities perceived as appropriate to the nurse-midwife by both groups, in addition to attitudes and values held by each group and perceptions of the nurse-midwife's role definition and role conflict themes as reported through the critical incident report. Data indicated that, although both groups basically held positive views of one another, inter-role conflict was present to some degree. Some issues of contention included support of breastfeeding and rooming-in, as well as support of women choosing prepared childbirth.

In order to provide the best care possible to the laboring woman, it is essential that the doula and nurse accept and respect each other's unique roles. For them to accomplish this, each must identify any negative feeling they may harbor toward one

another. The purpose of the current pilot study was to examine the level of acceptance shown by the intrapartum nurse for doula support. The focus of the study was the mother's perception of this level of acceptance because the nurse and doula's relationship will impact her comfort with her total care during labor. Consequently, the following clinical question was examined: To what level do intrapartum nurses accept doula support, as perceived by the patient?

METHODS

Because little to no research explores the relationship between doulas and intrapartum nurses, a qualitative approach was used. This study was conducted involving English-speaking women who gave birth to a healthy infant with the assistance of a professional doula in a hospital in north central Alabama. Women whose doulas were family members were excluded, as were any women whose infants were born with a major medical condition. Women who had utilized the services of a doula were contacted by that doula and asked to call or email the researcher if they were interested in participating in the study. The researchers obtained approval from the university's institutional review board and informed consent from participants. Questionnaires were sent and returned via email. The questions were approved by a panel of experts that included a doctorally prepared nurse educator with experience in research and obstetrics, a certified nurse-midwife with over 20 years of experience working with nurses and doulas, a registered nurse with six years of experience in labor and birth, and a certified doula and childbirth educator. Interview questions were as follows:

1. During your labor and birth, what measures of support were used by your doula?
2. How would you describe the relationship between your doula and your nurse?
3. At any time during your labor or birth, did you observe any conflict between your doula and your nurse? If so, what was the conflict about and how do you think it affected your labor?
4. Were any of the support measures provided by the doula questioned by your nurse? If so, please describe.
5. Were any of the support measures provided by your doula discontinued at the nurse's request? If so, please describe.
6. At any time during your labor and birth, did the support provided by your doula interfere with the medical care the nurse was providing? If so, how was that handled by the nurse and your doula?
7. Were there any events during your labor and birth involving the nurse and doula that increased or decreased your satisfaction with your overall birth experience?
8. Overall, would you say that the intrapartum nurse accepted the support provided by your doula?

To establish inter-rater reliability, themes were identified by the investigators and reviewed for validity by a panel of experienced researchers, including a baccalaureate-prepared registered nurse, a doctoral level research student, and a nursing educator.

TABLE 1
Support Measures Provided During Labor

Physical		Psychosocial	
Nurse	Doula	Nurse	Doula
Holding legs	Massage	Verbal encouragement	Verbal encouragement
Vital signs	Counter pressure		Music
IV insertion	Assistance with bath/shower		Calm environment
Cervical exams	Coached breathing		Reassurance
	Positioning		Presence
	Walking		Focus
	Swaying		Love
	Homeopathic remedies		
	Ice chips		
	Birthing ball		
	Warm compress		

TABLE 2
Participants' Perceptions of Nurses' Attitudes

Acceptance and Affirmation	Resentment and Animosity
''[The nurse] commented that having a doula for my continuous support freed her to focus on more mundane tasks of charting and monitoring, as well as attending to other patients.''	''. . .seemed to want me to suffer because I wasn't doing things her way''
''open-minded''	''had nothing to do with us, personally''
''supportive''	''closed-minded''
''accepting''	''bad attitude''
	''seemed to feel threatened''
	''rather negative''
	''unhappy''
	''wanted me to have a medicalized birth''
	''out to get me''

RESULTS

Eleven questionnaires were emailed to participants who expressed interest in participating in the study. Nine questionnaires were completed and returned. Participants were all Caucasian women ranging in age from 21 to 40 years, with a mean age of 33.7 years. All participants gave birth vaginally. Five of the eight women were primiparas, and four were multiparas.

The study participants were asked about the support provided by their doula and by their intrapartum nurse. The results were arranged in subcategories of physical and psychosocial (see Table 1).

In this study, levels of acceptance toward doula support offered by intrapartum nurses were divided into two themes:

1. Acceptance and affirmation
2. Resentment and animosity.

Participants' perceptions of the nurse's attitude toward the support provided by their doula is outlined in Table 2. Those participants who perceived their nurse as accepting and affirming of their doula support described that relationship as ''respectful,'' ''cooperative,'' ''kind,'' ''worked well together,'' ''no resentment,'' and ''got along very well.'' Those women who perceived their nurses as resentful and full of animosity regarding the support provided by their doula described that relationship as ''hostile,'' ''confrontational,'' ''with the potential to get ugly,'' ''not the best of friends,'' ''slight tension,'' and ''no relationship at all.'' Some of the conflicts expressed by the latter group of women centered on external fetal monitoring, nonadherence to a previously agreed upon birth plan, the mother's position during the second stage of labor, drinking during labor, and the use of nipple shields for breastfeeding. Women reported that these conflicts had a negative impact on their birth experience. One participant reported that ''it took energy to tune the nurse out,'' while another described her birth experience as ''a nightmare.'' In contrast, when the doula-nurse relationships were categorized into the theme of acceptance and affirmation, women described their birth experience as ''extremely positive,'' ''empowering,'' and ''life changing.''

When participants were asked for recommendations for nurses and doulas working together, all advice was directed toward nurses and other medical staff. Direct quotes from participants are outlined in Table 3.

Resentment and animosity detected in the nurse's attitude could potentially be attributed to an intrusive or hostile attitude from the doula. However, in this small study, that did not seem to be the case. Doulas were described as ''calm,'' ''respectful,'' and ''the best investment I have ever

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TABLE 3
Participants' Advice for Doulas and Nurses Working Together

''Nurses should be positive and encouraging.''
''Medical personnel shouldn't feel threatened or displaced just because a doula is present.''
''Take mothers' wishes into consideration before acting.''
''The choice to give birth without medication should be supported.''
''Recognize that doulas are not there to take over your job but just to provide comfort and support for the mom.''

made in my life.'' None of the participants reported that any support provided by their doula interfered with the medical care provided by the nurse.

DISCUSSION

The current study raises questions that will be useful in a follow-up study. The dichotomy suggested by this study indicates that, while some intrapartum nurses are perceived to view the doula's role as positive and one that may even facilitate their own responsibilities, others are perceived as viewing the doula's role in negative terms. The reason some nurses are not accepting of doula support cannot be fully understood without further research. Do nurses feel their role is threatened by the presence of a doula? Do they believe the presence of a doula hinders a safe labor and birth? Are they so accustomed to a medicalized birth that they are unable or unwilling to adapt to an alternative support person? These nurses may possibly be unaware that the patient perceives their attitudes as negative. It is also possible that the presence of a doula factors little into their resentful attitude. Perhaps these nurses were just having a bad day or the unit was understaffed, or they would be viewed as having a negative attitude even in the absence of a doula. These are all questions that must be answered with future studies. Nurses themselves should be interviewed to investigate how they feel about doula support. Doulas should also be interviewed to see if their perception of nurses' attitudes coincides with that of the patient. Further research should also examine if the nurse is resentful because of the presence of a doula or because the mother chose to give birth naturally, without many of the medical interventions provided to most patients.

Limitations in this study include an all-Caucasian population and a regional bias. In future research, doula support of Hispanic, Asian, or African-American women must be examined. Would nurses be more or less likely to accept doula support if it were viewed from a cultural perspective? Because this study was conducted in the Southeast, little is known about how nurses from other parts of the United States view doula support. It could be assumed that in areas of the country where midwives, doulas, and natural childbirth are more popular, intrapartum nurses would accept the doula's role more readily.

Nurses must recognize that their attitude regarding their patient's choice for doula support has a significant impact on the patient's perception of her birth experience. Acceptance and affirmation of the patient's wishes can lead to a positive and empowering birth, while resentment and animosity may only scar the patient's memories of what should be a joyous occasion. The key lies in nursing education. If some nurses feel threatened by doula support, it is plausible that the doula's role is misunderstood. Doulas should be invited to speak to obstetrical nursing students to clarify their role and educate these future nurses about how the two can work together. Doulas should also be encouraged to visit their client's intended hospital unit before the birth event in order to introduce themselves to the nurses and clarify their role. Nurses should be encouraged to attend doula workshops to receive firsthand knowledge of the support measures doulas are trained to provide.

Nurses themselves should be interviewed to investigate how they feel about doula support.

An unexpected finding among several of the participants was a delay in going to the hospital. Two of the women surveyed gave this as a reason for the positive relationship between their nurse and doula. As one women stated, ''I was only at the hospital for 2 hours and 7 minutes before my baby was born. My doula was only there for an hour. I am sure the short amount of time and absence of the nurse affected the interaction between the doula and nurse.'' Another woman said, ''I was at home for almost my entire labor, and only drove to the hospital when I was ready to push. The nurse didn't get to see much of my labor stage.'' One must wonder why these women decided to labor at home instead of at the hospital where they gave birth. Were they anticipating rejection by the hospital staff regarding their doula support? Were they afraid of being subjected to medical interventions they did not desire? This is an area for further investigation.

CONCLUSIONS

Although it is encouraging that some nurses accept and affirm doula support, 4 out of 9 women surveyed revealed that the doula support they chose was viewed by the nurse with animosity and resentment. While a nurse's primary role is to provide medical care for a laboring mother, her duties

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also include psychological and emotional support. Based on this and previous studies, many nurses fail, or are unable, to provide the latter. Clearly, this is why many women choose to hire a doula. Nurses must recognize that the doula is there to "fill in the gap" by offering the numerous comfort measures and intense emotional support nurses are unable to offer because of the enormous responsibility of providing adequate medical care to both mother and baby. Nurses will enhance patient satisfaction if they embrace this idea and recognize a doula can facilitate their own role. Doulas must also acknowledge that they are present strictly to provide support and advocacy, not to make medical decisions. If both members of this labor team are able to distinguish each other's roles, they can work together to provide women with safe and rewarding births.

IMPLICATIONS FOR CHILDBIRTH EDUCATORS

Some childbirth educators also fulfill the doula role, but many do not. In either case, childbirth educators can assist couples to review the pros and cons of selecting and obtaining the services of a doula.

Childbirth educators can also include comments on the outcomes of doula services from couples who previously attended their class. The information gained will assist the childbirth educator to match the referral of doula services to the stated desires of the expectant couple. The expectant mother who plans an epidural or cesarean birth may want a different doula than the mother who wants the best support available to achieve a normal birth.

Childbirth educators may also be in a position to know which local hospitals have nursing staff that work readily with doulas and which doulas can skillfully handle a situation where nursing staff is resistant to their presence. Additionally, childbirth educators may know which doulas support the techniques taught in their classes, as well as which doulas will support the desired role of the woman's partner or family members.

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